

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11299

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston - Rural</b>		c. LENGTH OF STAY IN 1b —			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dover Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Elizabeth</b>	Middle <b>Louise</b>	Last <b>Conaway</b>		
4. DATE OF DEATH	Month <b>October</b>	Day <b>17</b>	Year <b>19 59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>July 31, 1955</b>	9. AGE (In years last birthday) <b>4 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Williamsburg, Md., R.F.D.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ollie L. Conaway</b>		14. MOTHER'S MAIDEN NAME <b>Louise Adams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Ollie L. Conaway, Williamsburg, Md., R.F.D.</b>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>096.9</b>		<b>Convulsions</b> <b>27m-</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>None</b>		<b>Probably Urinary Infection</b> <b>24hr -</b>			
DUE TO (b) <b>None</b>					
DUE TO (c) <b>None</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Near Murlock,</b>	(County) <b>Maryland</b> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Dawson O. George</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>10-20-59</b>
EXAMINER'S NAME (Type) <b>DAWSON O. George</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 20, 1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Washington Cemetery</b>	22d. LOCATION (City, town, or county) <b>Near Murlock, Maryland</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalsburg, Maryland</b>			24a. REC'D BY REGISTRAR <b>OCT 22 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Albert S. Krause</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BT BROWNSAGE - BROWN'S FARMING & GARDENING  
MAGAZINE 1873-1874; FIFTH IMAGE TAKEN

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11210

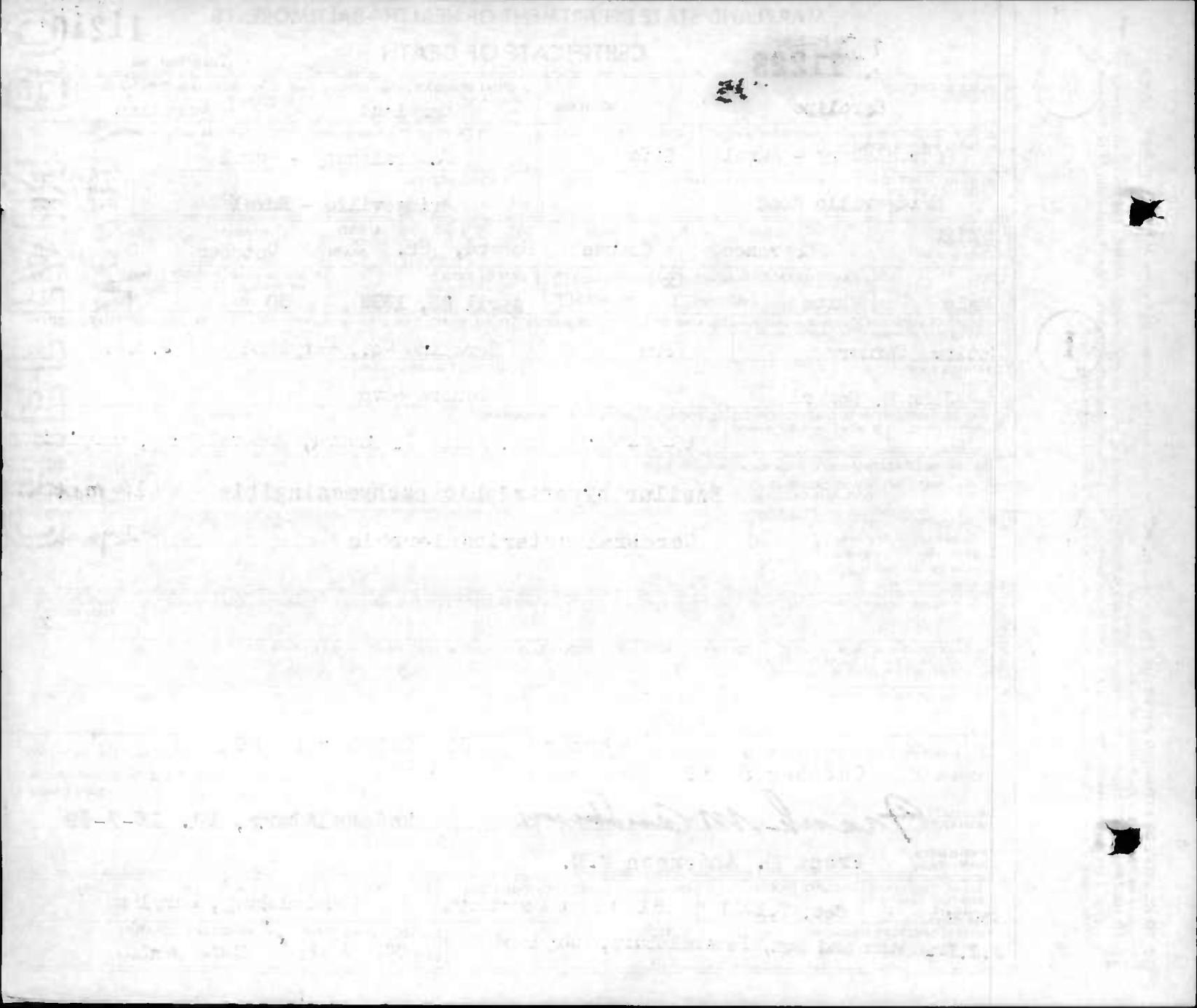
11228

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg - Rural</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Caroline</b>				
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Federalsburg - Rural</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bridgeville Road</b>						d. STREET ADDRESS <b>/ Bridgeville - Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>First Lawrence Middle Claude Last Howard, Sr.</b>		4. DATE OF DEATH <b>October 5, 1959</b>		Month <b>October</b>		Day <b>5</b>		Year <b>1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 23, 1899</b>	9. AGE (In years lost birthday) <b>60 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 24 HRS Hours <b>0</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>	11. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	12. BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>	13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
14. FATHER'S NAME <b>John W. Howard</b>				14. MOTHER'S MAIDEN NAME <b>Lenora Love</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-36-0020</b>		INFORMANT <b>Mrs. Alice T. Howard, Federalsburg, Maryland</b>		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Basilar hypertrophic pachymeningitis</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> 2 years DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from <b>February 1959</b> , to <b>October 5, 1959</b> , that I last saw the deceased alive on <b>October 5, 1959</b> , and that death occurred at <b>5:25A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Frank M. Anderson M.D.</b> PHYSICIAN'S NAME (Type) <b>Frank M. Anderson M.D.</b> <b>Federalsburg, Md. 10-7-59</b>												
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 7, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) <b>Federalsburg, Maryland</b>		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>												
ADDRESS <b>J.J. Frampton and Son, Federalsburg, Maryland</b>						24a. REC'D BY REGISTRAR DATE <b>OCT 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Orville &amp; Thorne</b>				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2 FilmG249 10-9-59 et

11211

11229

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland b. COUNTY		Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro		c. LENGTH OF STAY IN lb 35-Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro		(Correct)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Correct) Collins Nursing Home				d. STREET ADDRESS		None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lillie	Middle Legar	Last	4. DATE OF DEATH	Month 10	Day 2	Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH No Record	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Penns.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME No Record				14. MOTHER'S MAIDEN NAME No Record					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address Easton, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  442 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b)  DUE TO  Generalized Arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  Fracture of left femoral neck								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Greensboro, Md.	(County)	(State)
21. I certify that I attended the deceased from Sept. 15, 1957 to Oct. 2, 1959, that I last saw the deceased alive on Oct. 2, 1959, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED Oct. 3, 1959									
ACTUAL SIGNATURE Charles H. Stonesifer M.D.									
PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-5-59		22c. NAME OF CEMETERY OR CREMATORIUM Greensboro		22d. LOCATION (City, town, or county) Greensboro, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaire		ADDRESS Greensboro, Md.		24a. REC'D BY REGISTRAR DATE OCT 6 '59		24b. REGISTRAR'S SIGNATURE Arthur & Anna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

NAME OF DECEASED	
JAMES R. HARRIS	
ADDRESS	
1010 E. 36TH ST.	
Baltimore, MD 21218	
CITY, STATE, ZIP CODE	
DEATH DATE	
12/20/1998	
TIME OF DEATH	
10:00 AM	
CAUSE OF DEATH	
Hypertension	
AGE AT DEATH	
75 years	
SEX	
Male	
RACE	
White	
RELIGION	
Catholic	
EDUCATION	
High School Graduate	
EMPLOYMENT	
Retired	
MARRIED	
Yes	
NAME OF SPOUSE	
Mary	
NAME OF CHILDREN	
None	
NAME OF DOCTOR	
Dr. John Smith	
NAME OF FUNERAL HOME	
John Smith Funeral Home	
NAME OF CHURCH	
St. Peter's Catholic Church	
NAME OF CEMETERY	
St. Peter's Cemetery	
NAME OF ATTORNEY	
None	
NAME OF NOTARY PUBLIC	
John Smith, Notary Public	
SIGNATURE	
John Smith	

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11212

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		CAROLINE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		RURAL DENTON		a. STATE		b. COUNTY	
c. LENGTH OF STAY IN lb		30 yrs		MARYLAND		CAROLINE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		x RURAL Denton	
				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
JOHN				MURRAY	OCT	6	1959	

5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years at birthday) yrs.	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	AUG 12, 1890	69	Months Days	Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMER (OWNER)	FARMING	ILLINOIS	USA

13. FATHER'S NAME	DAVID MURRAY	14. MOTHER'S MAIDEN NAME	UNKNOWN
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO		HUR. JOHN MURRAY DENTON	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 431X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		Myocarditis Acute few minutes-

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
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20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
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ACTUAL SIGNATURE	Dawson O. George	DATE SIGNED
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EXAMINER'S NAME (Type)	Dawson O. George	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
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22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county)	(State)
Burial Oct 9, 1959		Denton	Denton	Ted

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Arthur E. Haas		OCT 13 '59	Arthur E. Haas

STATE OF HAWAII - DEPARTMENT OF  
EDUCATION - CERTIFICATE OF DOBAN



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11213

11231

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>CAROLINE</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>	c. LENGTH OF STAY IN lb <i>3 yrs</i>	b. COUNTY <i>CAROLINE</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		d. STREET ADDRESS <i></i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>PHILLIP</i>	First <i></i>	Middle <i></i>	Last <i>MURRAY</i>		
4. DATE OF DEATH <i>Oct 1 1959</i>	Month <i>Oct</i>	Day <i>1</i>	Year <i>1959</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAR 2, 1891</i>		
9. AGE (In years last birthday) yrs. <i>68</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm hand</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>WILLIAM MURRAY</i>	14. MOTHER'S MAIDEN NAME <i>AMANDA HUGHES</i>	Address <i>Denton, Md.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>	16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>ESTER MURRAY</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive heart disease</i> DUE TO <i>443X</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <i></i> DUE TO <i></i> (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>acute viral syn</i> 8 days.	INTERVAL BETWEEN ONSET AND DEATH <i>8 yrs</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>Oct 1 1959</i> , to <i>Oct 1 1959</i> , that I last saw the deceased alive and <i>Denton 1 1959</i> , and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>E Paul Knotts</i> PHYSICIAN'S NAME (Type) <i>E Paul Knotts</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Oct 4 1959</i>	22b. DATE THEREOF <i>Oct 4 1959</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Spring Grove</i>	22d. LOCATION (City, town, or county) <i>Denton, Md.</i>	(State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. V. Moore, Son, Denton, Md.</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE <i>OCT 8 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knott</i>		

18. COMITATO DI VISIONE SULLA NUOVA STATEGIA NAZIONALE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11232 CERTIFICATE OF DEATH

11214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Goldsboro</b>		c. LENGTH OF STAY IN 1b <b>25 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Goldsboro</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>				d. STREET ADDRESS <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First <b>Ann</b>	Middle <b>Payet</b>	Lost	4. DATE OF DEATH <b>10</b>	Month <b>1</b>	Day <b>19</b>	Year <b>59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-1-1870</b>	9. AGE (In years lost birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months <b>89</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>France</b>		12. CITIZEN OF WHAT COUNTRY? <b>France</b> ✓			
13. FATHER'S NAME <b>John Almand</b>				14. MOTHER'S MAIDEN NAME <b>No Record</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Marie Gasche Goldsboro, Maryland</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <b>420.1</b>		DUE TO  <b>Coronary Occlusion</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.  (b)		DUE TO  <b>Arteriosclerotic Cardiovascular Dis.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<b>Diabetes Mellitus</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m.      19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Greensboro, Md.</b>		20f. (City or town) <b>Greensboro</b>		(County) <b>Caroline</b>	(State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>Apr. 10, 1957</b> to <b>Oct. 1, 1959</b> , that I last saw the deceased alive on <b>Oct. 1, 1959</b> , and that death occurred at <b>9:40 P.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			DATE SIGNED <b>10-2-59</b>
ACTUAL SIGNATURE <i>Charles H. Stonesifer</i>		M.D.							
PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-3-59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Holy Cross</b>		22d. LOCATION (City, town, or county) <b>Greensboro, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Boulaire Greensboro, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>OCT 6 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur &amp; Kline</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18 MARYLAND STATE GOVERNMENT OF MARYLAND BALTIMORE

CERTIFICATE OF DEATH

44-3700

REGISTRATION

NAME

SEX	AGE	DEATH DATE	TIME	CAUSE	DEATH CERTIFIED
MALE	10	APRIL 1940	10:00 A.M.	COUGHING	BY DOCTOR
DECEASED RESIDED AT			DECEASED DIED AT		
101 E. 20TH ST. BALTIMORE			101 E. 20TH ST. BALTIMORE		
NAME OF DOCTOR			NAME OF HOSPITAL		
DR. JAMES R. COOPER			MARYLAND HOSPITAL		
ADDRESS OF DOCTOR			ADDRESS OF HOSPITAL		
101 E. 20TH ST. BALTIMORE			101 E. 20TH ST. BALTIMORE		
NAME OF FUNERAL DIRECTOR			NAME OF CEMETERY		
J. W. COOPER			BALTIMORE CEMETERY		
ADDRESS OF FUNERAL DIRECTOR			ADDRESS OF CEMETERY		
101 E. 20TH ST. BALTIMORE			101 E. 20TH ST. BALTIMORE		
NAME OF PERSON FILING			NAME OF PERSON SIGNING		
J. W. COOPER			J. W. COOPER		
ADDRESS OF PERSON FILING			ADDRESS OF PERSON SIGNING		
101 E. 20TH ST. BALTIMORE			101 E. 20TH ST. BALTIMORE		
SIGNATURE			SIGNATURE		
J. W. COOPER			J. W. COOPER		
DATE			DATE		
APRIL 1940			APRIL 1940		

RECORDED IN MARYLAND DEPARTMENT OF PUBLIC SAFETY AND JUSTICE, BALTIMORE, ON APRIL 19, 1940.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11215

11233

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BURRSVILLE</b>	c. LENGTH OF STAY IN lb <b>life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BURRSVILLE</b>	d. STREET ADDRESS <b>X</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>HARRY</b>	Middle <b>ANDERSON</b>	Last <b>PORTER</b>		
4. DATE OF DEATH	Month <b>OCT.</b>	Day <b>20</b>	Year <b>1959</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 29, 1877</b>		
9. AGE (In years lost birthday) <b>82 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>GROCERY</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>WESLEY PORTER</b>	14. MOTHER'S MAIDEN NAME <b>LAWRA ANDERSON</b>	Address <b>Tyre Anna Porter,</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>{</b> <b>(b)</b> DUE TO <b>(c)</b> DUE TO <b>General Arteriosclerosis</b>	INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Denlon</b>	20f. (City or town) <b>Denlon Md.</b>	(County) <b>Greensboro, Md.</b>	(State) <b>Oct. 21 '59</b>
21. I certify that I attended the deceased from <b>Apr. 10, 1958</b> , to <b>Oct. 20, 1959</b> , that I last saw the deceased alive on <b>Oct. 19, 1959</b> , and that death occurred at <b>4:30A</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Charles H. Stonesifer, M.D.</b>	ADDRESS (Street, city or town, state) <b>Greensboro, Md.</b>			DATE SIGNED <b>Oct. 21 '59</b>	
PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 22, 1959</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Denlon</b>	22d. LOCATION (City, town, or county) <b>Denlon Md.</b>	(State) <b>Oct. 26 '59</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Thorne</b>	ADDRESS <b>Denlon</b>	24a. REC'D BY REGISTRAR <b>Arthur S. Thorne</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thorne</b>		

## CALIFORNIA STATE DEPARTMENT OF HEALTH - SAN FRANCISCO

## CERTIFICATE OF DEATH

RECEIVED

DEPT. OF

HEALTH

SAN FRANCISCO

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CALIFORNIA

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11216

11234

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridgely</b>	c. LENGTH OF STAY IN lb <b>50 Yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridgely</b>	d. STREET ADDRESS <b>None</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary</b>	First <b>Mary</b>	Middle <b></b>	Lost <b>Slow</b>
4. DATE OF DEATH <b>10</b>	Month <b>10</b>	Day <b>20</b>	Year <b>19 59</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-10-1876</b>
9. AGE (In years lost birthday) <b>83</b>		10. IF UNDER 1 YEAR Months <b></b>	11. IF UNDER 24 HRS. Days <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>William Armstrong</b>		14. MOTHER'S MAIDEN NAME <b>Emeline Murphy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Charles Slow Ridgely, Maryland</b>
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized Arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 1, 1958, to Oct. 20, 1959, that I last saw the deceased alive on Oct. 20, 1959, and that death occurred at 5 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Charles H. Stonesifer, M.D.</i>		Greensboro, Md. Oct. 21 '59	
PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-23-59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Denton</b>
22d. LOCATION (City, town, or county) <b>Denton, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulaire Greensboro, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 26 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frazer</b>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. Pages 1 & 2 should be filed with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11235

## CERTIFICATE OF DEATH

Reg. Dist. No.

11217

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg		d. STREET ADDRESS Denton Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Denton Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Myrtle	Middle Etta	Lost Turner	4. DATE OF DEATH October 20	Month 19	Day 59	Year
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1899		9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frank Dickerson				14. MOTHER'S MAIDEN NAME Clara Friend				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-03-3528		17. INFORMANT James A. Turner, Federalburg, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 hour				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Federalburg		(County) Maryland (State)
21. I certify that I attended the deceased from Oct. 20, 1959, to Oct. 20, 1959, that I last saw the deceased alive on Oct. 20, 1959, and that death occurred at 4:15 PM, from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) DATE SIGNED Frank M. Anderson 304 N. Central, Federalburg								
ACTUAL SIGNATURE Frank M. Anderson M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Oct. 24, 1959 - Burial		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM Federal Hill Cemetery		22d. LOCATION (City, town, or county) Federalburg, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalburg, Maryland				24a. REC'D BY REGISTRAR DATE OCT 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

MANUFACTURED STATE OF MICHIGAN - DEATH

CERTIFICATE OF DEATH

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11236

## CERTIFICATE OF DEATH

12391

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston		c. LENGTH OF STAY IN 1b 8 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle L. Lost Williams		4. DATE OF DEATH Month October Day 15 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 18, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Murphy		14. MOTHER'S MAIDEN NAME Emma Carroll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-09-0742	
17. INFORMANT No		Mrs. Lee Price, Williamson St., Preston, Md.	
18. CAUSE OF DEATH [Enter only one cause per-line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  260x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Generalized Arterosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10-28-35	
DUE TO Diabetes Mellitus. Severe			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-28-1939, to Oct 15, 1939, that I last saw the deceased alive on Oct 13, 1939, and that death occurred at 10:45 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Federalsburg Md. DATE SIGNED 10-16-39	
ACTUAL SIGNATURE W. E. Lennon M.D.			
PHYSICIAN'S NAME (Type) W. E. Lennon M.D.		22d. LOCATION (City, town, or county) Near Preston, Md. (State)	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF Oct. 18, 1959	
22g. NAME OF CEMETERY OR CREMATORIAL Grove Cemetery		22h. LOCATION (City, town, or county) Near Preston, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son		ADDRESS Federalsburg, Md.	
24a. REC'D BY REGISTRAR OCT 20 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - CALIFORNIA, 19

CERTIFICATE OF DEATH

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